2003 Appendix A: Technical Notes

Births and Deaths

APPENDIX A: TECHNICAL NOTES

Vital Statistics Registration in Utah

Centralized vital statistics registration for the State of Utah was first established by act of the Utah Legislature in 1905. Sections 26-2-1 through 26-2-28, Utah Code Annotated, 1953 as amended, provide the current statutory authority[1].

Section 26-2-3

(1) The department shall:

(a) provide offices properly equipped for the preservation of vital records made or received under this chapter;

(b) establish a statewide vital records system for the registration, collection, preservation, amendment, and certification of vital records and other similar documents required by this chapter and activities related to them, including the tabulation, analysis, and publication of vital statistics;

(c) prescribe forms for certificates, certification, reports, and other documents and records necessary to establish and maintain a statewide system of vital records;
(d) prepare an annual compilation, analysis, and publication of statistics derived from vital records; and

(e) appoint a state registrar to direct the statewide system of vital records.

(2) The department may:

(a) divide the state from time to time into registration districts; and

(b) appoint local registrars for registration districts who under the direction and supervision of the state registrar shall perform all duties required by them by this chapter and department rules.

Under Utah's statutes, full-time health officers of local health departments become ex officio local registrars and are responsible for the registration of certificates for all births and deaths that occur within their respective jurisdictions. Figure A-1 is a list of local health departments, registrars and deputy registrars. Each of the twelve local health departments reside over a local health district.

The local health districts (also referred to as "districts" in this report) and respective counties are Bear River (Box Elder, Cach and Rich), Central Utah (Juab, Millard, Piute, Sanpete, Sevier and Wayne), Davis, Salt Lake, Southeastern (Carbon, Emery, Grand and San Juan), Southwest (Beaver, Garfield, Iron, Kane and Washington), Summit, Tooele, Tri-county (Daggett, Duchesne, and Uintah), Utah, Wasatch, and Weber-Morgan (Morgan and Weber). Figure A-2 is a Utah map which shows the county boundaries.

Source of Data

Vital statistics certificates filed with the state Office of Vital Records and Statistics are the primary source of data presented within this report. These records include certificates of live birth, death and fetal death. Source data of official population estimates for the state are provided by the Govenor's Office of Planning and Budget.

Forms for certificates

Utah's certificates of live birth, death and fetal death are revised periodically to include items on the recommended national "Standard Certificates," with modifications and additions to meet particular needs in Utah. Figures A-3 through A-6 show current copies of the Certificate of Live Birth, Certificate of Death, and Fetal Death Certificate.

Quality and Limitations of Data

Limitations of the data must be recognized before valid interpretation is possible. For vital statistics data, these limitations are related to the difficulties in reporting and classifying information and to some under-registration of events. It is necessary to exercise particular caution when evaluating vital statistics trend data, since medical concepts, code definitions and method of assigning causes of death have changed over the years. There was a major change in the death coding system for data year 1999 when ICD-10 was implemented.

Figure A-1

Local Health Districts, Registrars and Deputy Registrars
October 2004

Bear River District
655 East 1300 North
Logan, Utah 84341

Registrar: John C. Bailey
Deputy Registrar: Leslie Olson

Central Utah District
70 Westview Drive
Richfield, Utah 84701

Registrar: Robert Resendes
Deputy Registrar: Dixie Sorensen

Davis County
50 East State Street
Farmington, Utah 84025-0618

Registrar: Lewis Garrett
Deputy Registrar: Karla Smith

Salt Lake Valley Health Dept.
610 South 200 East
Salt Lake City, Utah 84111

Registrar: Patty Pavey
Deputy Registrar: Ellen Freeman

Southeast Utah District
28 South 100 East
P.O. Box 800
Price, Utah 84501

Registrar: David Cunningham
Deputy Registrar: Jeanne Thompson

Southwest Utah Public Health
168 North 100 East
St. George, Utah 84770

Registrar: Gary Edwards
Deputy Registrar: Sandra Stubblefield

Summit County Public Health
85 North 50 East
Coalville, Utah 84017

Registrar: Steve Jenkins
Deputy Registrar: RaNae Crittenden

Tooele County
151 North Main
Tooele, Utah 84074

Registrar: Myron Bateman
Deputy Registrar: Nikki Scow

Tri County District
147 East Main
Vernal, Utah 84078

Registrar: Joseph Shaffer
Deputy Registrar: Crystal Slaugh

Utah County
151 South University Avenue
Provo, Utah 84601

Registrar: Joseph K. Miner
Deputy Registrar: Ruth Nelson

Wasatch City/County
55 South 500 East
Heber City, Utah 84032-1918

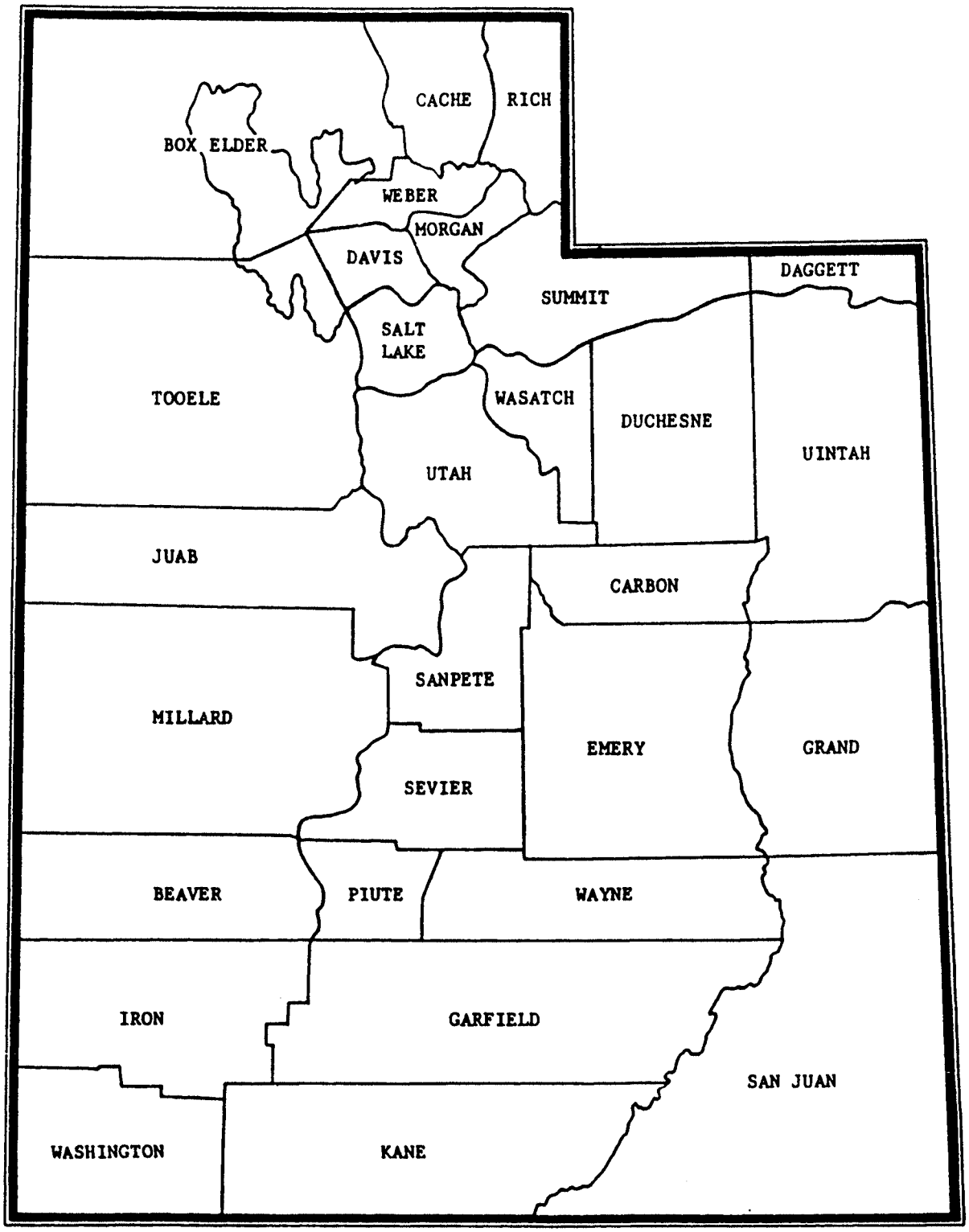
Registrar: Phil D. Wright
Deputy Registrar: Janet Norton

Weber/Morgan District
2570 Grant Avenue
Ogden, Utah 84401

Registrar: Gary House
Deputy Registrar: Lynette Satterfield

Figure A-2

MAP OF UTAH WITH COUNTY BORDERS



STATE OF UTAH - DEPARTMENT OF HEALTH

CERTIFICATE OF LIVE BIRTH

LOCAL FILE NUMBER

STATE BIRTH NUMBER

CHILD

1. CHILD'S NAME — FIRST — MIDDLE — LAST

2. SEX

3a. DATE OF BIRTH (Month, Day, Year)

3b. TIME OF BIRTH (24 Hour Clock)

4a. PLACE OF BIRTH ☐ Hospital ☐ Freestanding Birthing Center ☐ Clinic/Doctor's Office ☐ Residence Planned ☐ Residence Unplanned ☐ Other

4b. PLACE OF BIRTH - HOSPITAL NAME (if not in hospital, give street and number)

4c. CITY, TOWN, OR LOCATION OF BIRTH

4d. COUNTY OF BIRTH

Access to the information on this form is limited by the Utah Vital Statistics Act and Rule

HOSPITAL CERTIFIER

5a. I CERTIFY THAT THIS CHILD WAS BORN ALIVE AT THE PLACE AND TIME AND ON THE DATE STATED ABOVE. Signature

5b. DATE SIGNED (Month, Day, Year)

5c. CERTIFIER'S NAME & TITLE ☐ Hospital Administrator ☐ Designated Representative ☐ Other

MEDICAL ATTENDANT

6a. I CERTIFY THAT THIS CHILD WAS BORN ALIVE AT THE PLACE AND TIME AND ON THE DATE STATED ABOVE. Signature

6b. DATE SIGNED (Month, Day, Year)

6c. ATTENDANT'S NAME AND TITLE (MD, DO, CERTIFIED NURSE MIDWIFE, OTHER MIDWIFE, OTHER)

6d. MAILING ADDRESS OF ATTENDANT (Street, or RFD. No., City or Town, State, Zip)

MOTHER

7a. MOTHER'S NAME — FIRST — MIDDLE — LAST

7b. MAIDEN LAST NAME

8. DATE OF BIRTH (Month, Day, Year)

9. STATE OF BIRTH (if not in USA, name country)

10a. RESIDENCE - STREET AND NUMBER OF RESIDENCE

10b. CITY, TOWN, OR LOCATION

10c. INSIDE CITY LIMITS ☐ YES ☐ NO

10d. COUNTY

10e. STATE

11a. MOTHER'S MAILING ADDRESS (if same as above, enter zip code only)

11b. CITY OR TOWN

11c. STATE

11d. ZIP CODE

FATHER

12. FATHER'S NAME — FIRST — MIDDLE — LAST

13. DATE OF BIRTH (Month, Day, Year)

14. STATE OF BIRTH (if not USA, name country)

SIGNATURE

15a. I certify that the personal information provided on this certificate is correct to the best of my knowledge and belief. (Signature of Parent or other informant)

15b. PARENTS REQUEST SOCIAL SECURITY ISSUANCE ☐ YES ☐ NO

15c. IMMUNIZATION REGISTRY: I wish to enroll my child in the Immunization Registry ☐ YES ☐ NO

REGISTRAR

16a. REGISTRAR'S SIGNATURE

16b. DATE RECEIVED

UDHBVR2A, Rev. 10/97

Figure A-3

CONFIDENTIAL INFORMATION FOR MEDICAL AND HEALTH USE ONLY (UCA 26-2 AND 26-25)

COMPLETION INSTRUCTIONS

It is the responsibility of the attendant to complete all of the following items.

17a. MOTHER'S NAME (First, Middle, Last)

17b. SOCIAL SECURITY NUMBER

18a. FATHER'S NAME (First, Middle, Last)

18b. SOCIAL SECURITY NUMBER

19. Has a relative of the baby had a hearing loss that existed since childhood? (Permanent, Hereditary loss)
1 ☐ YES 2 ☐ NO

20. MOTHER OF HISPANIC ORIGIN?
YES 1 ☐ NO 2 ☐
If yes, indicate
1 ☐ Mexican 3 ☐ Puerto Rican
2 ☐ Cuban 4 ☐ Other Hispanic (Specify) _____

21. MOTHER'S RACE - American Indian (Tribe may be entered), Black, White, Japanese, etc. (Specify below)

22a. MOTHER'S OCCUPATION WORKED LAST YEAR

22b. KIND OF INDUSTRY OF BUSINESS

22c. EDUCATION (specify only highest grade completed) Elementary or secondary (0 through 12), College (13 through 16 or 17+)

23. MOTHER MARRIED? (At birth, conception, or any time between)
1 ☐ YES 2 ☐ NO

24. MOTHER'S HEIGHT AND WEIGHT
Mother's height:
_____feet _____Inches

Weight **Before** Pregnancy:
_____lbs.

Weight gained or lost **during** pregnancy
_____lbs.

25. OTHER RISK FACTORS FOR THIS PREGNANCY
Tobacco Use during Pregnancy
Average number of Cigarettes **per day**
1st TRI_____
2nd TRI_____
3rd TRI_____

Alcohol Use during Pregnancy
Average number of drinks **per week**
1st TRI_____
2nd TRI_____
3rd TRI_____

26. FATHER OF HISPANIC ORIGIN?
YES 1 ☐ NO 2 ☐
If yes, indicate
1 ☐ Mexican 3 ☐ Puerto Rican
2 ☐ Cuban 4 ☐ Other Hispanic (Specify) _____

27. FATHER'S RACE - American Indian (Tribe may be entered), Black, White, Japanese, etc. (Specify below)

28a. FATHER'S OCCUPATION WORKED LAST YEAR

28b. KIND OF INDUSTRY OF BUSINESS

28c. EDUCATION (specify only highest grade completed) Elementary or secondary (0 through 12), College (13 through 16 or 17+)

29. MEDICAL RISK FACTORS FOR THIS PREGNANCY (check all that apply)
☐ 01 Anemia (Hct <30/Hgb <10)
☐ 02 Cardiac Arrest
☐ 03 Acute or chronic lung disease
☐ 21 Pre-Existing Diabetes (Type I or II)
☐ 22 Gestational Diabetes
☐ 05 Genital Herpes
☐ 06Hemoglobinopathy
☐ 07 Polyhydramnios/Oligohydramnios
☐ 08 Hypertension, chronic
☐ 09 Hypertension, pregnancy associated
☐ 10 Eclampsia
☐ 11 Incompetent cervix
☐ 12 Previous infant 4000+ grams
☐ 13 Previous preterm infant
☐ 14 Previous S-F-G-A infant
☐ 15 Renal disease
☐ 16 Rh sensitization
☐ 17 Rubella
☐ 18 Uterine bleeding
☐ 0 None
☐ 19 Other (specify)_____
☐ 20 Unknown

30. DATE OF LAST NORMAL MENSES (Month, Day, Year)

31. MONTH OF PREGNANCY PRENATAL CARE BEGAN 1ST, 2ND, 3RD, ETC.

32. NO. OF PRE - NATAL VISITS

33. MOTHER TRANSFERRED PRIOR TO DELIVERY?
If Yes, enter name and State of facility transferred from:

34. PREGNANCY HISTORY (Complete each section)

LIVE BIRTHS (Do not include this child)		OTHER TERMINATIONS (Spontaneous and induced at any time after conception)
34a. Now Living	34b. Now Dead	34d.
Number_____ ☐ None	Number_____ ☐ None	Number_____ ☐ None
34c. DATE OF LAST LIVE BIRTH (Month, Day, Year)		34e. DATE OF LAST OTHER TERMINATION (Month, Year)

35 ANTEPARTUM PROCEDURES DURING THIS PREGNANCY (Check all that apply)
☐ 1 Amniocentesis
☐ 2 Electronic fetal monitoring
☐ 3 Induction of labor
☐ 4 Stimulation of labor
☐ 5 Tocolysis
☐ 6 Ultrasound
☐ 0 None
☐ 7 Other (specify)

36 METHOD OF DELIVERY (Check all that apply)
☐ 1 Vaginal
☐ 2 Vaginal birth after previous C-section
☐ 3 Primary C-section
☐ 4 Repeat C-section
☐ 5 Forceps
☐ 6 Vacuum

37 COMPLICATIONS OF LABOR AND/OR DELIVERY (Check all that apply)
☐ 1 Febrile (>100 F. or 38 C.)
☐ 2 Meconium, moderate/heavy
☐ 3 Premature rupture of membrane
☐ 4 Abruptio placenta
☐ 5 Placenta previa
☐ 6 Other excessive bleeding
☐ 7 Seizures during labor
☐ 8 Precipitous labor (<3 hours)
☐ 9 Prolonged labor (>20 hours)
☐ 10 Dysfunctional labor
☐ 11 Breech/Malpresentation
☐ 12 Cephalopelvic disproportion
☐ 13 Cord prolapse
☐ 14 Anesthetic complications
☐ 15 Fetal distress
☐ 0 None
☐ 16 Other (specify)_____
☐ 17 Unknown

38. BIRTH WEIGHT (grams)

39. THIS BIRTH SINGLE, TWIN, TRIPLET, ETC.

40. IF NOT SINGLE, BIRTH BORN 1ST, 2ND, 3RD

41. CLINICAL ESTIMATE OF GESTATION
_____number of weeks

42. APGAR SCORE
1 minute 5 minutes

43. INFANT TRANSFERRED?
1 ☐ YES 2 ☐ NO
If Yes, enter name of facility transferred to:

44. ABNORMAL CONDITIONS OF THE NEWBORN (Check all that apply)
☐ 1 Anemia (Hct <39/Hgb<13)
☐ 2.Birth injury
☐ 3.Fetal alcohol syndrome
☐ 4.Neonatal meningitis
☐ 5.Congenital infection
☐ 6.Hyaline membrane disease/RDS
☐ 7. Meconium aspiration syndrome
☐ 8. Assisted Ventilation <30 min.
☐ 9. Assisted ventilation > 30 min.
☐ 10. Seizures
☐ 11. Neonatal substance abuse
☐ 00. None
☐ 12. Other (specify)_____
☐ 13. Unknown

51. CONGENITAL ANOMALIES OF CHILD (Check all that apply)
☐ 1 Anencephalus
☐ 2 Spina Bifida/Meningocele
☐ 3 Hydrocephalus
☐ 4 Microcephalus
☐ 5 Other central nervous system (specify)_____
☐ 6 Heart malformations (specify) _____
☐ 7 Other circulatory anomalies (specify) _____
☐ 8 Respiratory anomalies (specify)_____
☐ 9 Rectal atresia
☐ 10 Tracheo-esophageal fistula/esophageal atresia
☐ 11 Omphalocele/Gastroschisis
☐ 12 Other gastrointestinal (specify)_____
☐ 13 Malformed genitalia
☐ 14 Renal agenesis
☐ 15 Other urogenital anomalies (specify)_____
☐ 16 Cleft lip/palate
☐ 17 Polydactyly/Syndactyly/Adactyly
☐ 18 Club foot
☐ 19 Diaphragmatic hernia
☐ 20 Other musculoskeletal/integumental anomalies (specify)_____
☐ 21 Down's syndrome
☐ 22 Other chromosomal anomalies (specify)_____
☐ 23 Multiple anomalies
☐ 0 None
☐ 24 Other (specify)
_____
☐ 25 Unknown

46. IS INFANT DECEASED?
1 ☐ YES 2 ☐ NO

47. HEPATITIS B VACCINATION GIVEN?
1 ☐ YES 2 ☐ NO
IF YES, DATE GIVEN (Month, Day, Year)

Figure A-4

Figure A-5

Access to information on this form is limited under the Vital Statistics Act and Rules.

STATE OF UTAH - DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

LOCAL FILE NUMBER

STATE FILE NUMBER

USE PERMANENT BLACK INK

DECEDENT

1. NAME OF DECEDENT — FIRST — MIDDLE — LAST
2. SEX
3a. DATE OF DEATH *(Mo., Day, Yr.)*
3b. TIME OF DEATH *(24 hr. clock)*
4. DATE OF BIRTH *(Mo., Day, Yr.)*
5. AGE- *Last Birthday* — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Minutes
6. BIRTHPLACE *(City & State or Foreign Country)*
7. SOCIAL SECURITY NUMBER
8a. PLACE OF DEATH *(check only one)* — HOSPITAL *(status codes for Hospital only)*: ☐ 1. Inpatient ☐ 2. ER/Outpatient ☐ 3. DOA — ALL OTHER LOCATIONS: ☐ 5. Nursing Home ☐ 6. Residence (any) ☐ 7. Other *(specify)* _____
8b. NAME OF HOSPITAL, NURSING HOME OR OTHER FACILITY *(if outside a facility, give street address of location)*
8c. CITY, TOWN, OR LOCATION OF DEATH
8d. COUNTY OF DEATH
9. SURVIVING SPOUSE *(if wife, give maiden name)*
10. WAS DECEDENT EVER IN THE U.S. ARMED FORCES? ☐ 1. Yes ☐ 2. No
11. MARITAL STATUS ☐ 1. Never Married ☐ 2. Married ☐ 3. Widowed ☐ 4. Divorced
12a. DECEDENT'S USUAL OCCUPATION *(Give kind of work done during most of working life. Do **NOT** enter retired)*
12b. KIND OF BUSINESS OR INDUSTRY
13a. RESIDENCE - STREET AND NUMBER
13b. CITY, TOWN OR COMMUNITY
13c. COUNTY
13d. STATE
13e. INSIDE CITY LIMITS? ☐ 1. Yes ☐ 2. No
13f. ZIP CODE
14. WAS DECEDENT OF HISPANIC ORIGIN? ☐ 1. Yes ☐ 2. No *(if yes, Specify)* ☐ 1. Mexican ☐ 2. Cuban ☐ 3. Puerto Rican ☐ 4. Other (Specify) _____
15. RACE - Black, White, Am. Indian (tribe may be entered), Japanese, etc. (Specify)
16. EDUCATION *(specify only highest grade completed)* Elementary or Secondary (0-12) College (13-16 or 17+)

PARENTS

17. FATHER'S NAME *(First, Middle, Last)*
18. MAIDEN NAME OF MOTHER *(First, Middle, Last)*

INFORMANT

19. NAME, RELATIONSHIP AND MAILING ADDRESS OF INFORMANT

DISPOSITION

20. METHOD OF DISPOSITION ☐ 1. Entombment ☐ 2. Donation ☐ 3. Other ☐ 4. Burial ☐ 5. Cremation ☐ 6. Removal
21a. DATE OF DISPOSITION
21b. PLACE OF DISPOSITION *(name of cemetery, crematory, or other place)*
21c. LOCATION - City or Town, State
22. SIGNATURE OF FUNERAL SERVICE LICENSEE
23. LICENSEE NUMBER
24. FUNERAL HOME *(Name and address)*

CERTIFIER

25. DATE DECEASED WAS LAST ATTENDED BY CERTIFYING PHYSICIAN
26. If not certified by medical examiner, was death reported to M.E.? ☐ 1. Yes ☐ 2. No If yes, enter the date and hour reported. M.E. CASE NO._____ HR. ____ MO ____ DAY ____ YEAR ____
27a. CERTIFIER
☐ 1. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.
☐ 2. MEDICAL EXAMINER/LAW ENFORCEMENT OFFICIAL: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, place and due to the cause(s) and manner as stated.
27b. SIGNATURE AND TITLE OF CERTIFIER
27c. LICENSE NUMBER
27d. DATE SIGNED *(Month, Day, Year)*
28. NAME AND ADDRESS OF PERSON WHO CERTIFIED THE CAUSE OF DEATH (Item 31) *(Type/Print)*

REGISTRAR

29. REGISTRAR'S SIGNATURE
30a. DATE REGISTRAR NOTIFIED OF DEATH *(Mo., Day, Yr.)*
30b. DATE FILED *(Mo., Day, Yr.)*

CAUSE OF DEATH

31. PART I. ENTER THE DISEASES, INJURIES, OR COMPLICATIONS THAT CAUSED THE DEATH. DO NOT ENTER THE MODE OF DYING, SUCH AS CARDIAC OR RESPIRATORY ARREST, SHOCK, OR HEART FAILURE. LIST ONLY ONE CAUSE ON EACH LINE. *Approximate Interval Between Onset and Death.*

IMMEDIATE CAUSE *(Final disease or condition resulting in death)*
a. _____ DUE TO (OR AS A CONSEQUENCE OF):
b. _____ DUE TO (OR AS A CONSEQUENCE OF):
c. _____ DUE TO (OR AS A CONSEQUENCE OF):
d. _____

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST

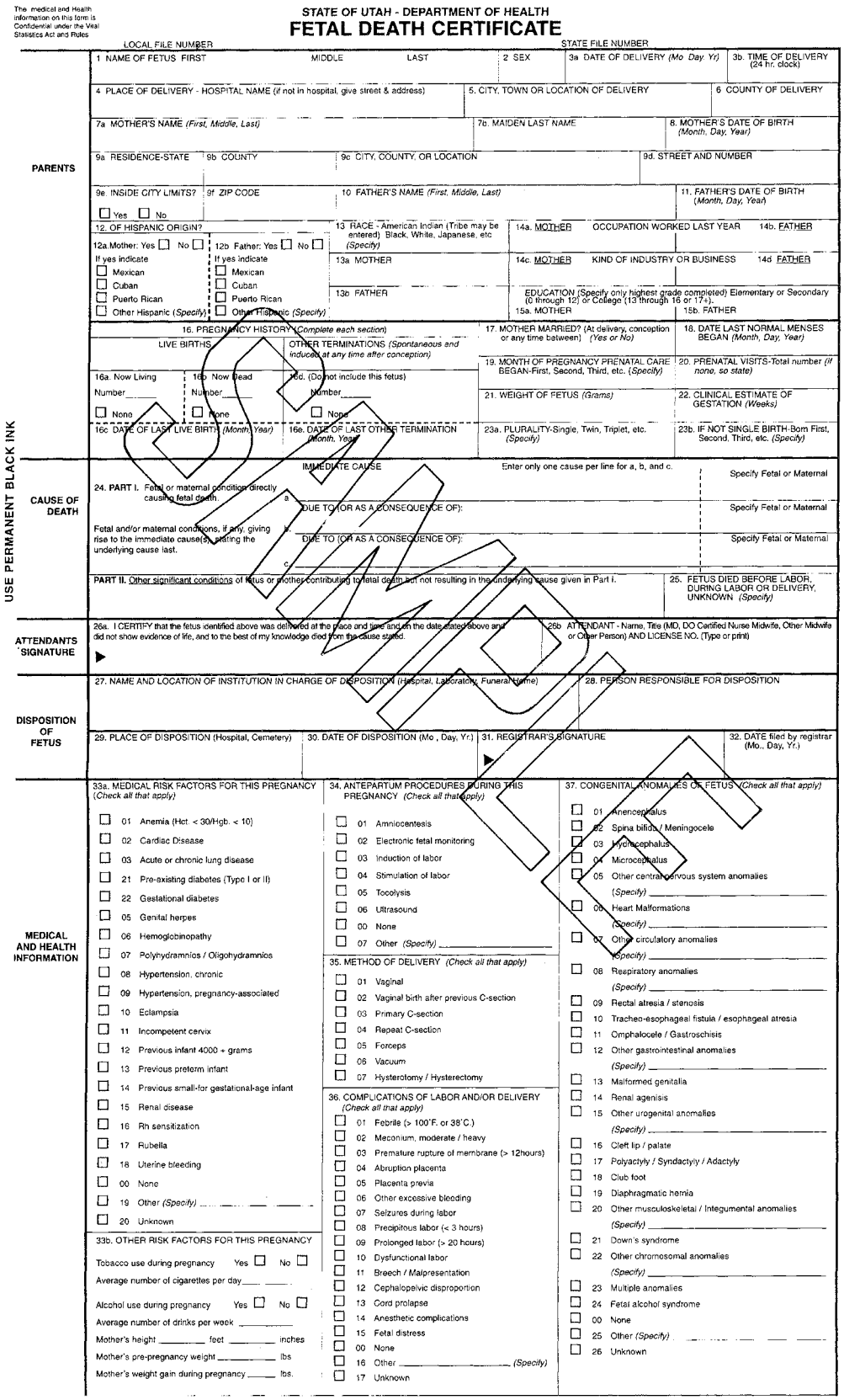
PART II. Other Significant Conditions contributing to death but not resulting in the underlying cause given in Part I

32. IN YOUR OPINION, TOBACCO USE BY THE DECEDENT: ☐ 1. Probably contributed to the cause of death. ☐ 2. Was the underlying cause of death. ☐ 3. Did not contribute to the cause of death. ☐ 4. Is unknown in relation to the cause of death. ☐ 5. NON USER ☐ 6. UNKNOWN IF USER
33a. WAS AN AUTOPSY PERFORMED? ☐ 1. Yes ☐ 2. No
33b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? ☐ 1. Yes ☐ 2. No

34. MANNER OF DEATH ☐ 1. Natural ☐ 2. Accident ☐ 3. Suicide ☐ 4. Homicide ☐ 5. Undetermined ☐ 6. Pending Investigation — If injured Purposely or Accidently
35a. DATE OF INJURY *(Mo., Day, Yr.)*
35b. TIME OF INJURY *(24 Hour Clock)*
35c. INJURY AT WORK? ☐ 1. Yes ☐ 2. No
35d. PLACE OF INJURY - *At home, farm, street, factory, office, building, etc. (specify)*
35e. LOCATION *(Street or rural route number, city or town, county and state.)*
35f. If motor vehicle accident specify if decedent was driver, passenger or pedestrian.
35g. DESCRIBE HOW INJURY OCCURRED *(enter sequence of events which resulted in injury, NATURE OF INJURY should be entered in item 31)*

UDH-BVR Form 12, Rev. 12/98

Figure A-6



The medical and Health information on this form is Confidential under the Vital Statistics Act and Rules

STATE OF UTAH - DEPARTMENT OF HEALTH

FETAL DEATH CERTIFICATE

LOCAL FILE NUMBER

STATE FILE NUMBER

USE PERMANENT BLACK INK

PARENTS

1 NAME OF FETUS FIRST MIDDLE LAST

2 SEX

3a DATE OF DELIVERY (Mo Day Yr)

3b. TIME OF DELIVERY (24 hr. clock)

4 PLACE OF DELIVERY - HOSPITAL NAME (if not in hospital, give street & address)

5. CITY, TOWN OR LOCATION OF DELIVERY

6 COUNTY OF DELIVERY

7a MOTHER'S NAME (First, Middle, Last)

7b. MAIDEN LAST NAME

8. MOTHER'S DATE OF BIRTH (Month, Day, Year)

9a RESIDENCE-STATE

9b COUNTY

9c CITY, COUNTY, OR LOCATION

9d. STREET AND NUMBER

9e. INSIDE CITY LIMITS? ☐ Yes ☐ No

9f ZIP CODE

10 FATHER'S NAME (First, Middle, Last)

11. FATHER'S DATE OF BIRTH (Month, Day, Year)

12. OF HISPANIC ORIGIN?

12a.Mother: Yes ☐ No ☐ If yes indicate ☐ Mexican ☐ Cuban ☐ Puerto Rican ☐ Other Hispanic (Specify)

12b Father: Yes ☐ No ☐ If yes indicate ☐ Mexican ☐ Cuban ☐ Puerto Rican ☐ Other Hispanic (Specify)

13 RACE - American Indian (Tribe may be entered) Black, White, Japanese, etc (Specify)

13a MOTHER

13b FATHER

14a. MOTHER OCCUPATION WORKED LAST YEAR 14b. FATHER

14c. MOTHER KIND OF INDUSTRY OR BUSINESS 14d FATHER

EDUCATION (Specify only highest grade completed) Elementary or Secondary (0 through 12) or College (13 through 16 or 17+).

15a. MOTHER 15b. FATHER

16. PREGNANCY HISTORY (Complete each section)

LIVE BIRTHS

16a. Now Living Number____ ☐ None

16b Now Dead Number____ ☐ None

OTHER TERMINATIONS (Spontaneous and induced at any time after conception)

16c. (Do not include this fetus) Number____ ☐ None

16c DATE OF LAST LIVE BIRTH (Month, Year)

16e. DATE OF LAST OTHER TERMINATION (Month, Year)

17. MOTHER MARRIED? (At delivery, conception or any time between) (Yes or No)

18. DATE LAST NORMAL MENSES BEGAN (Month, Day, Year)

19. MONTH OF PREGNANCY PRENATAL CARE BEGAN-First, Second, Third, etc. (Specify)

20. PRENATAL VISITS-Total number (if none, so state)

21. WEIGHT OF FETUS (Grams)

22. CLINICAL ESTIMATE OF GESTATION (Weeks)

23a. PLURALITY-Single, Twin, Triplet, etc. (Specify)

23b. IF NOT SINGLE BIRTH-Born First, Second, Third, etc. (Specify)

CAUSE OF DEATH

IMMEDIATE CAUSE Enter only one cause per line for a, b, and c.

24. PART I. Fetal or maternal condition directly causing fetal death.

a

DUE TO,OR AS A CONSEQUENCE OF):

Specify Fetal or Maternal

Fetal and/or maternal conditions, if any, giving rise to the immediate cause(s), stating the underlying cause last.

b.

DUE TO (OR AS A CONSEQUENCE OF):

Specify Fetal or Maternal

c.

PART II. Other significant conditions of fetus or mother contributing to fetal death but not resulting in the underlying cause given in Part I.

25. FETUS DIED BEFORE LABOR, DURING LABOR OR DELIVERY, UNKNOWN (Specify)

ATTENDANT'S SIGNATURE

26a. I CERTIFY that the fetus identified above was delivered at the place and time and on the date stated above and did not show evidence of life, and to the best of my knowledge died from the cause stated. ▶

26b ATTENDANT - Name, Title (MD, DO Certified Nurse Midwife, Other Midwife or Other Person) AND LICENSE NO. (Type or print)

DISPOSITION OF FETUS

27. NAME AND LOCATION OF INSTITUTION IN CHARGE OF DISPOSITION (Hospital, Laboratory, Funeral Home)

28. PERSON RESPONSIBLE FOR DISPOSITION

29. PLACE OF DISPOSITION (Hospital, Cemetery)

30. DATE OF DISPOSITION (Mo , Day, Yr.)

31. REGISTRAR'S SIGNATURE ▶

32. DATE filed by registrar (Mo., Day, Yr.)

MEDICAL AND HEALTH INFORMATION

33a. MEDICAL RISK FACTORS FOR THIS PREGNANCY (Check all that apply)

☐ 01 Anemia (Hct. < 30/Hgb. < 10)
☐ 02 Cardiac Disease
☐ 03 Acute or chronic lung disease
☐ 21 Pre-existing diabetes (Type I or II)
☐ 22 Gestational diabetes
☐ 05 Genital herpes
☐ 06 Hemoglobinopathy
☐ 07 Polyhydramnios / Oligohydramnios
☐ 08 Hypertension, chronic
☐ 09 Hypertension, pregnancy-associated
☐ 10 Eclampsia
☐ 11 Incompetent cervix
☐ 12 Previous infant 4000 + grams
☐ 13 Previous preterm infant
☐ 14 Previous small-for gestational-age infant
☐ 15 Renal disease
☐ 16 Rh sensitization
☐ 17 Rubella
☐ 18 Uterine bleeding
☐ 00 None
☐ 19 Other (Specify)
☐ 20 Unknown

33b. OTHER RISK FACTORS FOR THIS PREGNANCY

Tobacco use during pregnancy Yes ☐ No ☐

Average number of cigarettes per day____

Alcohol use during pregnancy Yes ☐ No ☐

Average number of drinks per week ____

Mother's height ____ feet ____ inches

Mother's pre-pregnancy weight ____ lbs

Mother's weight gain during pregnancy ____ lbs.

34. ANTEPARTUM PROCEDURES DURING THIS PREGNANCY (Check all that apply)

☐ 01 Amniocentesis
☐ 02 Electronic fetal monitoring
☐ 03 Induction of labor
☐ 04 Stimulation of labor
☐ 05 Tocolysis
☐ 06 Ultrasound
☐ 00 None
☐ 07 Other (Specify)

35. METHOD OF DELIVERY (Check all that apply)

☐ 01 Vaginal
☐ 02 Vaginal birth after previous C-section
☐ 03 Primary C-section
☐ 04 Repeat C-section
☐ 05 Forceps
☐ 06 Vacuum
☐ 07 Hysterotomy / Hysterectomy

36. COMPLICATIONS OF LABOR AND/OR DELIVERY (Check all that apply)

☐ 01 Febrile (> 100°F. or 38°C.)
☐ 02 Meconium, moderate / heavy
☐ 03 Premature rupture of membrane (> 12hours)
☐ 04 Abruption placenta
☐ 05 Placenta previa
☐ 06 Other excessive bleeding
☐ 07 Seizures during labor
☐ 08 Precipitous labor (< 3 hours)
☐ 09 Prolonged labor (> 20 hours)
☐ 10 Dysfunctional labor
☐ 11 Breech / Malpresentation
☐ 12 Cephalopelvic disproportion
☐ 13 Cord prolapse
☐ 14 Anesthetic complications
☐ 15 Fetal distress
☐ 00 None
☐ 16 Other (Specify)
☐ 17 Unknown

37. CONGENITAL ANOMALIES OF FETUS (Check all that apply)

☐ 01 Anencephalus
☐ 02 Spina bifida / Meningocele
☐ 03 Hydrocephalus
☐ 04 Microcephalus
☐ 05 Other central nervous system anomalies (Specify)
☐ 06 Heart Malformations (Specify)
☐ 07 Other circulatory anomalies (Specify)
☐ 08 Respiratory anomalies (Specify)
☐ 09 Rectal atresia / stenosis
☐ 10 Tracheo-esophageal fistula / esophageal atresia
☐ 11 Omphalocele / Gastroschisis
☐ 12 Other gastrointestinal anomalies (Specify)
☐ 13 Malformed genitalia
☐ 14 Renal agenisis
☐ 15 Other urogenital anomalies (Specify)
☐ 16 Cleft lip / palate
☐ 17 Polyactyly / Syndactyly / Adactyly
☐ 18 Club foot
☐ 19 Diaphragmatic hernia
☐ 20 Other musculoskeletal / Integumental anomalies (Specify)
☐ 21 Down's syndrome
☐ 22 Other chromosomal anomalies (Specify)
☐ 23 Multiple anomalies
☐ 24 Fetal alcohol syndrome
☐ 00 None
☐ 25 Other (Specify)
☐ 26 Unknown

The completeness of registration for births was last tested at the state level in conjunction with the 1950 U.S. Census of the Population and was found to be 98.7 percent complete at that time. At the present time, more than 99 percent of all Utah's resident births occur in hospitals. This fact, coupled with information from sample studies, indicates that the completeness of birth certificate registration now exceeds 99 percent.

The registration of fetal deaths at 20 weeks or more gestation is required by statute. Since May 1981, the institution where the delivery occurs has the responsibility for filing a fetal death certificate if the delivery results in a fetal death. Fetal death certificates are to be registered by the fifth day after the delivery and before disposition of the remains.

Most deliveries (99%) occur in hospitals and women who miscarry unexpectedly at 20 weeks or more are usually taken to a hospital if they are not already there. Funeral directors are responsible for checking that a fetal death certificate has been filed for all such dispositions they handle.

Limitation of Small Numbers

All statistics are subject to chance variation. Such random variation in a large number of events has little effect on the data for the group; however, random variation in a small number of events may result in a startling change in the data for the group. For example, minor differences in the number of births or deaths in small populations or in the number of deaths from uncommon causes may result in large changes in these rates. Rates for areas of small population or for events with few occurrences should be interpreted with this limitation in mind.

Cause of Death

Cause of death statistics are derived from the medical certification information required by law to be reported on the death or fetal death certificate by the attending physician or medical examiner. The medical certification item on certificates of death and fetal death has a provision for reporting three causes of death--immediate, intervening, and underlying, plus additional information related to the cause of death.

The cause of death selected for coding and tabulating mortality statistics is the "underlying cause of death," which is generally defined as the disease or injury which initiated the sequence of morbid events leading directly to death.

Occasionally death certificates are registered with the cause of death information incomplete, inconsistent, or equivocal, and additional information from the center is not available. In such cases, selection and modification rules are used to select the underlying cause of death for statistical purposes. Selection and modification rules which adapt the coding procedures to reporting practices in the United States are published by the Public Health Service, National Center for Health Statistics, in annual editions of the Vital Statistics Instructional Manual.

The Eigth Revision of the International Classification of Diseases was used to code the underlying cause of death on Utah's death certificates for data years 1968 through 1978. The Ninth Revision of the International Classification of Diseases was used to code the underlying cause of death in Utah for data years 1979-1998, and the current Tenth Revision was used to code the 1999-2003 data in this report.

Comparability ratios between revisions are computed by the National Center for Health Statistics and are published in Utah's Vital Statistics: Births and Deaths, 1980 for the earlier revision and can be found on our web site as described in the preface of this publication for the new and current version. Comparability ratios for some cause of death codes show extreme variations and utmost caution should be taken in interpreting any cause of death trends that span the Eighth and Ninth Revisions[2] or the Ninth and Tenth Revisions[3] of the International Classification of Diseases.

Geographic Bases

Birth and death data can be presented by place of occurrence of the event or by place of usual residence of the individual. For deaths, "place of residence" for the decedent is defined as the usual residence of the decedent. For births, "place of residence" for the child is defined as the usual residence of the mother.

Reallocation of birth and death certificates to the state of residence has been virtually complete on a nationwide basis since 1955. This is made possible by a cooperative program among the states for exchange of copies of certificates of non-resident events for statistical purposes only.

For analytical purposes, sometimes it is meaningful to tabulate accidental deaths by place of occurrence rather than by place of residence. Statistical tabulations of accidental deaths "by place of occurrence" refer to the place where the death occurred, and not the place where the accident occurred. A hypothetical example may help to clarify the above explanation. Assume that a resident of Denver, Colorado is involved in a motor vehicle accident in Wendover, Nevada and requires emergency aid of a special nature. The closest available facility is the Tooele Valley Hospital in Tooele, Utah. After arriving at the hospital, the patient succumbs to conditions arising from the accident. In such cases, the "place of occurrence" of the death for statistical purposes would be Tooele, Utah, not Wendover, Nevada; however, there can also be a table of accidental deaths by place where the accident occurred, In this example, the death would be classfied as an accidental death to a non-resident which occurred in Utah. The place where the accident occurred would be out-of-state (Wendover, Nevada).

Race/Ethnic Origin

The Utah Department of Health began tabulating birth data by race of mother in the 1990 data year. Prior to 1990, birth data was tabulated by race of infant.

This change corresponds to the 1989 revision of the Utah birth certificate. Caution should be used when comparing the racial classification of birth data prior to 1990 with data collected in 1990 and later. An explanation of the factors that brought about the racial classification change of birth data and the problems of analyzing the trend data is available in Utah's Vital Statistics Annual Report: 1990.

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[1] Utah State Legislature; Utah Code and Constitution/Title 26 -- Utah Health Code Sections 26-2-1 through 26-2-28 (Utah Code Annotated, 1953); Laws/Constitution web site www.le.state.ut.us.

[2] National Center for Health Statistics, "Estimates of selected comparability ratios based on dual coding of 1976 death certificates by the Eighth and Ninth Revisions of the International Classification of Diseases"; Monthly Vital Statistics Report, Vol. 28, No. 11(S); February 29, 1980.

[3] National Center for Health Statistics, (a) "Comparability of cause of death between ICD-9 and ICD-10: Preliminary estimates"; National Vital Statistics Report; Vol. 49, No. 2; 2001 and (b) "Deaths: Final data for 1999"; National Vital Statistics Reports: Vol. 49, No. 8; 2001.